

Privileges:

Hospital/Surgery Center: _____

Address: _____

Copy of Agreement given to:

Print Name

Title

Signature of Authorized Staff Member

Telephone #

.....

Privileges:

Hospital/Surgery Center: _____

Address: _____

Copy of Agreement given to:

Print Name

Title

Signature of Authorized Staff Member

Telephone #

I, _____, M.D., under penalty of perjury, state that I have provided a list of the name(s) and address(es) of all employers, hospitals and free standing surgery centers at which I have privileges to practice. I am also required to, under penalty of perjury, immediately notify the Board of any changes in employers, hospitals and free standing surgery centers at which I have privileges to practice during the term of this Agreement.

_____, M.D.